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BEFORE THE BOARD OF PATENT APPEALS AND INTERFERENCES

Application Number: 09/982,274
Filing Date: October 17, 2001
Appellant(s): LEVIN ET AL.

Paul D. Bianco
For Appellant

EXAMINER'S ANSWER

This is in response to the appeal brief filed 11/09/2009 appealing from the Office action mailed 6/09/2009.

(1) Real Party in Interest

A statement identifying by name the real party in interest is contained in the brief.

(2) Related Appeals and Interferences

The examiner is not aware of any related appeals, interferences, or judicial proceedings which will directly affect or be directly affected by or have a bearing on the Board's decision in the pending appeal.

(3) Status of Claims

The statement of the status of claims contained in the brief is correct.

(4) Status of Amendments After Final

The appellant's statement of the status of amendments after final rejection contained in the brief is correct.

(5) Summary of Claimed Subject Matter

The summary of claimed subject matter contained in the brief is correct.

(6) Grounds of Rejection to be Reviewed on Appeal

The appellant's statement of the grounds of rejection to be reviewed on appeal is correct.

(7) Claims Appendix

The copy of the appealed claims contained in the Appendix to the brief is correct.

(8) Evidence Relied Upon

6,039,688	DOUGLAS et al.	3-2000
4,831,526	LUCHS et al.	5-1989
5,867,821	BALLANTYNE et al.	2-1999

(9) Grounds of Rejection

The following ground(s) of

Claim Rejections - 35 USC § 103

The following is a quotation of 35 U.S.C. 103(a) which forms the basis for all obviousness rejections set forth in this Office action:

> (a) A patent may not be obtained though the invention is not identically disclosed or described as set forth in section 102 of this title, if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains. Patentability shall not be negatived by the manner in which the invention was made.

Claims 1-10 and 14-19 are rejected under 35 U.S.C. 103(a) as being unpatentable over Douglas et al. (hereinafter Douglas) (U. S. Patent No. 6,039,688), Luchs et al. (hereinafter Luchs) (U.S. Patent No. 4,831,526) and further in view of Applicant's admitted prior art.

Claim 1 recites a method of managing the use of a medical insurance plan by members thereof, the method comprising:

i. loading member application forms in a computer system managed by an insurance provider, wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values;

ii. receiving, at the computer system managed by the insurance provider, one of a premium payment and a contribution payment from members of the medical insurance plan, wherein the insurance provider

undertakes liability in the medical insurance plan in response to receiving one of the premium payment and the contribution payment (Douglas; col. 2, lines 9-22, col. 5, lines 28-34, col. 19, lines 26-);

iii. providing at least one of

relevant health services (Douglas; col. 2, lines 9-22, col. 5, lines 27-44, col. 6, lines 27-48), and

Also, Examiner notes that Applicant's admitted prior art, "the definition of business of a medical scheme" reads that the medical scheme is a business of undertaking liability in return for a premium or contribution…to render a relevant health service…by medical scheme itself (present specification; page 2).

And assistance in defraying expenses incurred in connection with rendering such relevant health services, by the computer system managed by the insurance provider to members who pay at least one of premium payment and the contribution payment;

iv. defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan (Douglas; col. 2, lines 9-22, col. 5, lines 28-34, col. 6, lines 7-13, 40-48);

v. offering, by the computer system managed by the insurance provider, the at least one of a plurality of health-related facilities and a

plurality of health- related services to members of the medical insurance plan (Douglas; Douglas; col. 2, lines 9-22, col. 5, lines 28-34, col. 6, lines 7-13, 40-48);

vi. monitoring, by the computer system managed by the insurance provider, usage of the at least one of a plurality of health-related facilities and a plurality of health-related services by each member (Douglas; col. 5, lines 28-34, col. 7, lines 54-65 and col. 10, lines 9-16);

vii. allocating, by the computer system managed by the insurance provider in response to the monitoring, a credit value to each member according to their use of the at least one of a plurality of health-related facilities and a plurality of health-related services (Douglas; col. 5, lines 28-34, col. 14, lines 38-42); and

viii. allocating, by the computer system managed by the insurance provider, rewards to members who accumulate credit values exceeding predetermined values (Douglas; col. 14, lines 42-47).

Douglas fails to expressly teach loading member application forms in a computer system managed by an insurance provider, wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values. However, these features are well known in the art, as evidenced by Luchs.

In particular, Luchs discloses feature, “a series of data comprising a form”(Luchs; abstract, col. 2, lines 26-30, col. 3, lines 17-38).

It would have been obvious to one having ordinary skill in the art at the time of the invention to include the aforementioned limitation as disclosed by Luchs, with the motivation of processing and preparing application for insurance and premium quotations and for preparing and writing insurance contracts.

Douglas fails to expressly teach that “the insurance provider undertakes liability in the medical insurance plan in response to receiving one of the premium payment and the contribution payment and providing, by the insurance provider, to members who one of pay such premiums and make such contributions, at least one of relevant health services, and assistance in defraying expenses incurred in connection with rendering such relevant health services.”

However, these features are well known in the art, as evidenced by Applicant’s admitted prior art.

In particular, Applicant’s admitted prior art discloses definition of the term "business of a medical scheme": the business of undertaking liability in return for a premium or contribution a) to make provision for the obtaining of any relevant health service; b) to grant assistance in defraying expenditure incurred in connection with the

rendering of any relevant health service; and c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme;" (par.: 0012-0016).

It would have been obvious to one having ordinary skill in the art at the time of the invention to include the aforementioned limitation as disclosed by Applicant's admitted prior art, which is the definition of a medical plan, with the motivation of providing clarification of the benefits of an insurance plan.

Claim 2 recites the method according to claim 1 wherein the at least one of a plurality of health-related facilities and a plurality of health-related services includes at least one of the group consisting of: membership of health clubs, membership of gymnasiums, membership of fitness programs, weight loss programs, and programs to quit smoking (Douglas; col. 5, line 60 to col. 6, line 6).

Claim 3 recites the method according to claim 2, wherein the at least one of a plurality of health-related facilities and a plurality of health-related services further includes predetermined preventive medical procedures (Douglas; col. 2, lines 23-47, col. 6, lines 7-13, 40-48).

Claim 4 recites the method according to claim 2, wherein the at least one of a plurality of health-related facilities and a plurality of health-related services further includes a medical advice service (Douglas; col. 14, lines 46-52 and col. 15, lines 1-4).

Claim 5 recites the method according to claim 2, wherein the at least one of a plurality of health-related facilities and a plurality of health-related services further includes predetermined procedures (Douglas; col. 15, lines 25-39).

Claim 6 recites the method according to claim 5, wherein the predetermined procedures include at least one of the group consisting of advance pre-authorization of hospitalization, advance pre-authorization of treatment, registration for electronic funds transfer, and compliance with preferred procedures (Douglas; col. 5, lines 45-51).

Claim 7 recites the method according to claim 1, wherein a reward allocated to a member is at least one of linked to a number of annual claims associated with the member and whether or not the member has been hospitalized in a predetermined period of time (Douglas; col. 14, lines 38-42 and col. 17, line 64 to col. 18, line 5, col. 20, lines 38-47).

Claim 8 recites the method according to claim 7, wherein the reward allocated to the member includes at least one of the group consisting of: prizes allocated on a basis of a draw, a magnitude of a member's credit value being related to a chance of winning the

draw, access to at least one of health-related facilities and health-related services for family members, decreased premium payments according to a predetermined plan, and increased benefit payments according to a predetermined plan (Douglas; col. 5, lines 52-59).

Claim 9 recites the method according to claim 1, wherein a reward allocated to a member is not actually given to the member before at least one of a predetermined period has passed or the member has attained a predetermined age (Douglas; col. 18, line 66 to col.19, line 2).

Claim 10 recites the method according to claim 9, wherein the reward allocated is forfeited by the member if they are not still a member of the medical insurance plan after the predetermined period has passed or after the member has attained such predetermined age (Douglas et al.; col. 14, lines 38-47).

Claim 14 recites the method according to claim 1, further comprises:

i. the insurance provider offering the at least one of a plurality of health-related facilities and a plurality of health-related services in conjunction with third party service providers that provide at least one of health related facilities and health-related services in the at least one of a plurality of health-related facilities and a plurality of health-related services offered by the insurance provider (Douglas; col. 5, lines 28-38); and

ii. monitoring usage of the at least one of health-related facilities and health-related services provided by the third party service providers by members by receiving information from the third party service providers detailing the usage of the at least one of health- related facilities and health-related services by the members (Douglas; col. 6, lines 2-6, Fig. 1).

Claim 15 recites the method according to claim 14, wherein the members only pay a once off activation fee to gain access to the at least one of a plurality of health-related facilities and a plurality of health-related services (Douglas; col. 2, lines 9-22).

Claim 16 recites the method of claim 1, further comprising: providing, by the insurance provider, one of a full payment and a partial payment to one of a health-related facility and a health-related service in the at least one of a plurality of health- related facilities and a plurality of health-related services that has been used by a member of the medical insurance plan, wherein the one of a full payment and a partial payment is on behalf of the member.

Douglas fails to expressly teach providing, by the insurance provider, one of a full payment and a partial payment to one of a health-related facility and a health-related service in the at least one of a plurality of health-related, facilities and a plurality of health-related services that has been used by a member of the medical insurance plan, wherein the one of a full payment and a partial payment is on behalf of the member.

However, these features are well known in the art, as evidenced by Applicant's admitted prior art.

In particular, Applicant's admitted prior art discloses definition of the term "business of a medical scheme": the business of undertaking liability in return for a premium or contribution a) to make provision for the obtaining of any relevant health service; b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme;" (par.: 0012-0016).

It would have been obvious to one having ordinary skill in the art at the time of the invention to include the aforementioned limitation as disclosed by Applicant's admitted prior art, which is the definition of a medical plan, with the motivation of providing clarification of the benefits of an insurance plan.

Claim 17 recites the method of claim 1, further comprising: providing, by the insurance provider, discounted usage fees to the members for the at least one of a plurality of health-related facilities and a plurality of health-related services.

Douglas fails to expressly teach providing, by the insurance provider, discounted usage fees to the members for the at least one of a plurality of health-related facilities and a plurality of health-related services.

However, these features are well known in the art, as evidenced by Applicant's admitted prior art.

In particular, Applicant's admitted prior art discloses definition of the term "business of a medical scheme": the business of undertaking liability in return for a premium or contribution a) to make provision for the obtaining of any relevant health service; b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme" (par.: 0012-0016).

It would have been obvious to one having ordinary skill in the art at the time of the invention to include the aforementioned limitation as disclosed by Applicant's admitted prior art, which is the definition of a medical plan, with the motivation of providing clarification of the benefits of an insurance plan

Claims 18 and 19 repeat the same limitation of claim 1, therefore this claim is rejected for the same reasons given above in the rejection of claim 1 and incorporated herein.

Claim 12 is rejected under 35 U.S.C. 103(a) as being unpatentable over Douglas et al. (hereinafter Douglas) (U.S. Patent No. 6,039,688), Luchs et al. (hereinafter Luchs) (U.S.

Patent No. 4,831,526), Applicant's admitted prior art and further in view of Ballantyne et al. (hereinafter Ballantyne) (U.S. Patent No. 5,867,821).

Claim 12 recites the method according to claim 3 wherein the preventive medical procedures include vaccinations.

Douglas fails to expressly teach the vaccination information. However, this feature is well known in the art, as evidenced by Ballantyne.

In particular, Ballantyne discloses vaccination information (Ballantyne; col. 15, lines 41-47).

It would have been obvious to one having ordinary skill in the art at the time of the invention to include the aforementioned limitation as disclosed by Ballantyne with the motivation of enhancing healthcare quality (Ballantyne; col. 2, lines 55-62).

(10) Response to Arguments

Argument A:

"Whether amendment filed February 17, 2009 introduced new material into the disclosure" (page 6-8 of arguments).

The added material: "a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values", Appellant points out figure 1 (column MH/U/W Ops.) and figures 3, 7 and 10, however the Appellant describes the information under "employer" column in page 7 of the arguments. The only description under "employer" in

figure 1 is “((Employer) complete employer application form including employer level decision -compulsory, voluntary, or disallow Vitality membership for employees”). And specification recites: "FIG. 1 shows the procedure followed by a new employer joining a medical scheme (i.e. traditional indemnity health insurance plan) that utilizes the present invention. (In the specification, reference is made to the "Vitality" program of the applicant. It should be appreciated that the described scheme may not correspond exactly to medical schemes operated by the applicant from time to time.)” in page 4, first paragraph. Even if we assume that ”a default setting” is filling out a form, and checking a box for accepting membership of Vitality; then figures 1, 3, 7, 10 all describe different situations, such as figure 1: “New employer joins vitality”, figure 3: “Claim vitality points for existing HRC/RWFL membership”, figure 7: “Member/dependant visits run/walk for life”, and figure 10: “Score various vitality points” and not all of the figures recite a form that the employer completes.

It is already very confusing that the terms of "insurance provider", "Momentum Health" or "MH", "MH U/W Ops" where "U/W' is an abbreviation for "underwrite", "Discovery", and Scheme" have been used interchangeably in the Specification as originally filed to mean "insurance provider" (as explained by the Appellant in Remarks of 2/17/2009 communication); Appellant now points out all these figures of different situations as “a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values”.

Argument B:

Appellant argues: Douglas does not teach “insurance provider defines at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan” (claims 1 and 18, fifth limitation) (pages 11-14 of arguments).

Examiner respectfully submits that “business of a medical scheme” or “health insurance plan” is described in the present specification on page 2 as:

> “The South African "Medical Schemes Act, No. 131 of 1998", Chapter 1, Section 1 - Definitions, contains the following definition of the term "business of a medical scheme":
>
> "...the business of undertaking liability in return for a premium or contribution
>
> a) to make provision for the obtaining of any relevant health service;
>
> b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
>
> c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme;"
>
> …A medical scheme according to this definition will be understood by those skilled in the art as being equivalent to a traditional indemnity health insurance plan.
>
> The plurality of health-related facilities and/or services may include membership of health clubs, gymnasiums or fitness programs, weight loss programs or programs to quit smoking, for example.”

Therefore according to present specification, an insurance provider “grant assistance for a relevant health service” and “render a relevant health service, either by the medical scheme (insurance provider) or by any supplier in association with in terms of an agreement with a medical scheme”. Applicant (appellant) admits that “insurance provider renders a relevant health service to the members.

Douglas teaches “Referring to FIG. 1, in a presently preferred embodiment of the invention, the patient 10, physician 12, case advisor 14, and health plan payor 16 (such as an HMO, insurance company or self-insured employer), all provide input to and/or receive output from the therapeutic behavior modification program's compliance monitoring and feedback system.” (Douglas; col. 5, lines 28-34), therefore, payor inputs and receives output from the system.

Also, Douglas teaches “In an exemplary scenario, a physician diagnoses an individual with an ailment. The physician may then recommend a health care maintenance or recovery program which requires the patient to: take certain medications; participate in a support group; and control risk factors by altering his or her diet, following an exercise program, and managing stress levels.” (Douglas; col. 6, lines 7-13). Examiner considers that it makes more sense for a physician to recommend any health-relevant service such as exercising, since the physician knows about the patient’s detailed health conditions, and can recommend the optimum program for the patient rather than an insurance company asking a patient to do a certain exercise. The system of Douglas offers the patient health-related services, wherein the health plan payor is a component of the system. And since applicant’s specification describes that the insurance plan renders relevant health services to the members, insurance provider in Douglas would be able to input/output information about relevant health services for the members.

Appellant argues: Douglas does not teach “the rewards are allocated to members who accumulate credit values exceeding predetermined values”(pages 14-15 of the arguments); Examiner respectfully recites that Douglas teaches “…Users may earn

points by good participation in the program and by reaching certain milestones. For instance, points may be earned for good attendance at meetings, good participation during the meetings, chairing a meeting, or losing a certain amount of weight, if this was a goal to be accomplished." In col. 14, lines 37-47.

Argument C:

Argument C repeats the argument B.

Argument D:

Appellant argues: Luchs does not teach "wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding a predetermined values" (in page 16 of the arguments); Examiner respectfully submits that Luchs teaches "a computerized insurance premium quote request and policy issuance system" (title), where "To assist the operator in entering the appropriate data, a series of data comprising a **"form"** is displayed on his terminal by the central processor, and he merely enters the pertinent information in the blanks provided. This information constitutes such things as the insured's name and address, the risk to be insured, the limit of the insurance, and **any other information necessary in providing a policy application or premium quotation**. Although all of the data requested by the form must be completed in order to proceed with writing the insurance policy, for the purpose of quoting the premium which would be due, only certain minimal information need be entered. This information is correlated in the central processor, resulting in premium quotation data which is then transmitted back and displayed at the operator's terminal." In col. 3, lines 17-38. As

analyzed above in the section of B, the definition of insurance plan includes providing any relevant services to the members and as analyzed in section A, a default setting associated with the medical insurance plan is filling out a form, and checking the necessary parts of the form. Therefore Luchs teaches a default setting associated with the medical insurance plan.

Argument E:

The declaration includes a research paper (UBS Investment Research) authored by Michael Christelis and the first page of the research indicates "UBS does and seeks to do business with companies covered in its research reports. As a result, investors should be aware that the firm may have a conflict of interest that could affect the objectivity of this report. Investors should consider this report as only a single factor in making their investment decision." Therefore there is a conflict of interest between the author (and UBS) and the inventors (Discovery Holdings Ltd.).

The declaration states "...We believe that Vitality provides superior life insurance margins and medical scheme membership growth potential (despite its already large size) through selection effects, significantly lower mortality claims, health claims and lapse experience, and a brand of its own that has become a household name in the affluent market in South Africa...". Therefore the report provides other reasons for success of the Vitality and the success is not related with the claims.

(11) Related Proceeding(s) Appendix

No decision rendered by a court or the Board is identified by the examiner in the Related Appeals and Interferences section of this examiner's answer.

For the above reasons, it is believed that the rejections should be sustained.

Respectfully submitted,

/D. B. C./

Examiner, Art Unit 3626

Conferees:

/Robert Morgan/

Primary Examiner, Art Unit 3626

Vincent Millin/vm/

Appeals Practice Specialist